



MONTANA STATE PRISON HEALTH SERVICES OPERATIONAL PROCEDURE

Procedure No.: MSP HS E-13.0	Subject: DISCHARGE – MEDICAL EVALUATION AND PLANNING	
Revised: NCCHC Standard P-E-13,2014, HS D-02.0 Discharge Medications	Page 1 of 2 and 4 attachments	
Effective Date: November 1,2010	Revised: June 1, 2017	
Signature / Title: /s/ Cindy Hiner / Health Services Manager		
Signature / Title: /s/ Tristan Kohut, D.O. / Medical Director		

I. PURPOSE

To offer discharge planning to inmates with serious health needs upon notification of their imminent release (discharge, probation parole, etc.).

II. DEFINITIONS

Discharge planning – the process of providing sufficient medications and arranging for necessary follow-up health services before the inmate's release to the community.

Health care staff – the licensed health care providers (e.g., physicians, nurse practitioners, physician's assistants, dentists and nurses) responsible for inmate health care and treatment at MSP.

III. PROCEDURES

A. General requirements

1. Health care staff will initiate a discharge plan for an inmate with health conditions when notified of the inmate's anticipated release. If adequate notification is not provided, health care staff still have the responsibility to ensure that continuity of care is extended into the community for that inmate.
2. The designated Medical Case Manager, in consultation with a provider, will give each inmate with a health condition(s) an Acuity Ranking of 1-2-or-3 (*see attachment A*).
 - a. Inmates who receive an Acuity Ranking of 1 will receive a discharge plan that will include as needed: referral to a community agency or provider and an exchange of clinically relevant information with that provider, assistance in application for SSDI and SSI benefits if necessary, a discharge summary, a 30-day supply of medications (HS D-02.0), medical equipment defined by condition, and a 30-day supply of medical supplies.
 - b. Inmates who receive an Acuity Ranking of 2 will receive a discharge plan that will include as needed: referral to a community agency or provider and an exchange of clinically relevant information with that provider, assistance in application for SSDI and SSI benefits if necessary, a discharge summary, and a 30-day supply of medications.
 - c. Inmates who receive an Acuity Ranking of 3 will receive a discharge plan that will include as needed: a list of community agencies or providers, a discharge summary, a 30-day supply of medications, and instructions for access of medical records.
 - d. All medications will be provided in a child-proof container.
 - e. If an inmate is released without essential prescribed medication, the medication will be mailed to the inmate at the address given to the pharmacy. Inmate addresses can be found on the discharge paperwork from the MSP IPPO office.
 - f. The unit case manager, IPPO staff, and the Health Services Case Manager are available as a resource for assistance with discharge planning.

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- g. All discharging inmates will be given a written form letter that details contact information for the MSP Records Department and the process for accessing their medical records after discharge into the community.
3. Prior to release, the Medical Case Manager will provide inmates with discharge health care instructions.
 - a. Inmates with an Acuity Ranking of 1 will be scheduled by the Medical Case Manager to meet with health care staff for verbal and written discharge instructions.
 - 1) Discussion with the inmate will emphasize the importance of appropriate follow-up care and the recommendation for community follow-up care, as needed.
 - 2) The inmate will be informed and referred to available resources in the community, except when an inmate is being released with a reportable disease or other serious medical need. In that case, the Medical Case Manager will refer the inmate to the Montana Department of Public Health and Human Services, as required by public health laws, or specialized clinics and community health providers. An exchange of clinically relevant information will be communicated to the community provider or DPHHS via fax or electronic transferring of records at the time the appointment or referral is made.
 - 3) When appointments with community providers are made prior to discharge the inmate will be provided with written instructions for the appointment/s including; date, time, name of provider, and address of provider with telephone contact number will be given to the inmate as part of the discharge.
 - 4) The Medical Case Manager will confirm all scheduled community appointments prior to the discharge date and give the community provider any known contact information for the discharging inmates. i.e. known discharge address or telephone number. The Medical Case Manager will assure that the community provider has all necessary and relevant medical information.
 - b. The Medical Case Manager will provide written discharge instructions as needed to inmates with an Acuity Ranking of 2 and 3. They will receive a supply of medications and information concerning access of medical records.
4. The designated medical records staff will initiate the routing of the Medical Discharge Services Confirmation Form in a timely manner. The completed form will be placed in the Inmate's health record.
5. An inmate may refuse any part of the discharge plan. A refusal of treatment form will be signed by the inmate and witnessed by an MSP staff member. It will include detailed specifics of the refusal. Refusals will be in accordance to with *DOC 4.5.32, Right to Refuse Medical Treatment*.

IV. CLOSING

Questions concerning this operational procedure will be directed to the Health Services Manager

V. ATTACHMENTS

Acuity Ranking for Discharge- Medical Evaluation and Planning form	attachment A
MSP Health Care Discharge Summary form	attachment B
Health Information Request to Release Records (Release of Information)	attachment C
Medical Discharge Services Confirmation Form	attachment D

Acuity Ranking for Discharge- Medical Evaluation and Planning

Each medical release will be give an Acuity Ranking of **1-2-or-3**

The following inmates rate a Ranking of 1

- Inmates with Major Medical Problems requiring extensive medical care or active treatment such as renal dialysis or chemotherapy. Lack of ongoing care or treatment could result in immediate and serious consequences upon the day of, or within a few days following release.
- Inmates who are considered medically unstable with special medical equipment or medical supplies such as:
 - Glucometers
 - Wheelchairs
 - Canes, crutches, or other assistive devices
 - Specialized medical supplies - ostomy, catheter, etc.

Examples:

An inmate who routinely uses a sliding scale to adjust insulin dosing according to the glucometer readings.

An inmate who is not yet stabilized with oral or injectable medications.

The following inmates rate a Ranking of 2

- Inmates who may take many medications but are considered Medically Stable
- Inmates who have no immediate medical need at the time of release

The following inmates rate a Ranking of 3

- Inmates with little or no medical needs at release.

MSP Health Care Discharge Summary
NEED FOR FOLLOW-UP HEALTH CARE

Name of Inmate: _____

It has been explained to me that I have _____

(Name of Condition)

which requires medical follow-up with a health care provider. I understand that the recommended follow up includes:

1.

2.

3.

I understand that I am responsible for seeking health care services in the community. I understand that before the supply of medication provided by the Department of Corrections is depleted, I must see a community practitioner for renewal of the medication. I understand that I am financially responsible for the health care services that I seek.

SIGNED: _____ DATE: _____

Printed Name: _____

Witness: _____

(DOC Health Care Provider)

Health Information Request to Release Records

Patient Name: _____
DOC ID/AO Number: _____ Date of Birth: _____
Social Security Number: _____

1. I authorize the use or disclosure of the above named individual's health information as described below:

2. All health care information in your possession, whether generated by you or by any other source, may be released to me or to _____ [name person] for:

[purpose of the disclosure].

3. Covering the period(s) of healthcare:

From (date) _____ to (date) _____

From (date) _____ to (date) _____

4. Information to be disclosed:

- | | | |
|---|---|--|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Operative Notes |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Laboratory Tests | <input type="checkbox"/> Pathology Report |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Emergency Room Report | <input type="checkbox"/> X-ray/imaging Reports |
| <input type="checkbox"/> Immunization Record | <input type="checkbox"/> Complete Health Record | |
| <input type="checkbox"/> Other (please specify) _____ | | |

5. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) or Hepatitis A, B or C. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

6. The revocation is effective from the time it is communicated to the health care provider, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization is valid for up to 30 months from the date of execution below. If no expiration is specified this authorization will automatically expire six (6) months from the date of signing. This authorization does not permit the release of health care information relating to health care that the patient receives more than 6 months from the date of execution below. Mont. Code Ann. §50-16-527.

7. The Montana Department of Corrections, Montana State Prison, its health care providers, employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information pursuant to the Uniform Health Care Information Act, Mont. Code Ann. §50-16-501 through §50-16-553 or the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d..

8. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Signature of patient or patient's representative _____
Date

Relationship to the patient

Witness _____
Date



Montana State Prison Medical Services Discharge Form

NAME: _____ DOC ID# _____
Last First

DATE OF DISCHARGE: _____

DATE FORM INITIATED: _____

MEDICAL RECORD ACCESS LETTER GIVEN: YES/NO

MEDICAL RECORDS STAFF INITIALS: _____

MEDICATION BOTTLES/BLISTER PACKS ISSUED: YES/NO

PHARMACY STAFF INITIALS: _____

WRITTEN PRESCRIPTION WRITTEN (AS NEEDED): YES/NO

DISCHARGE PLANNER INITIALS: _____

DATE TO TRANSPORTATION: _____

PHARMACY STAFF INITIALS: _____

MEDICAL PACKET RECEIVED: YES/NO

TRANSPORTATION STAFF INITIALS: _____

PHARMACY STAFF INITIALS: _____

MEDICATIONS RECEIVED: YES/NO

TRANSPORTATION STAFF INITIALS: _____

DISCHARGE SUPPLIES: ☐ wheelchair ☐ diabetic supplies ☐ walker ☐ none

☐ other medical supplies: (list) _____

INMATE SIGNATURE: _____ DATE: _____

(By signing above, you verify that you have received your medical packet and all of your medications as indicated by stickers below)

WERE MEDICATIONS MAILED TO DISCHARGE ADDRESS: YES/NO

STAFF INITIALS: _____

PLACE MEDICATION STICKERS IN THIS AREA

Please route **COPY** of completed form to Discharge Planner
Please route **ORIGINAL** completed form promptly to medical records